Department of Health

Public health transfer from primary care trusts to local authorities

Staff working in public health are our greatest asset. In transferring primary care trust public health commissioning functions to local government, employers and trade unions are determined to ensure that staff are treated fairly and transparently.

Primary care trusts and local authorities will be responsible for developing public health transition plans and consulting with their constituent trade unions and staff on these and the associated workforce plans.

To support this, key guidance and support are being developed at national level, which outline the human resources (HR) processes and expectations on primary care trusts, councils, NHS and local government trade unions in managing this important change.

Public Health Human Resources Concordat

The Public Health HR Concordat, developed by the Department of Health with NHS Employers and the Local Government Association, and in partnership with NHS and local government trade unions, has been published.

This provides a best practice framework for organisational changes affecting staff as part of the transfer and sets out a range of principles and HR standards for managing the processes involved, complementing the HR Transition Framework.

The Concordat has the following objectives:

- provides guiding principles and HR standards for the transfer of primary care trust public health commissioning activity and functions ("senders") to local authorities ("receivers")
- provides a fair and consistent approach to managing the related detailed HR processes in a local context – advancing equality and promoting diversity
- outlines the indicative timescales for change and the requirements on NHS and local government employers and trades unions in managing this important change
- identifies where and when decisions will be made or where further detailed information can be obtained
- promotes effective partnership working and consultation with staff and trade unions across the NHS and local government.

It also sets out a series of agreed HR transition principles that should apply throughout the transition, including:

- consult and engage early with employees and their representatives, making sure they are kept fully informed and supported during the change process
- actively promote equality and diversity standards through all transfer, selection and appointment processes
- ensure professional behaviour towards all employees moving between organisations so they are treated with dignity and respect
- work with pace to minimise disruption and uncertainty for employees affected by change
- ensure the consistent treatment of employees at all levels
- ensure that all reasonable steps are taken to avoid redundancies to ensure that valuable skills and experience are retained
- highlight necessary compliance with relevant employment legislation.

It explains that it is the responsibility of all employers involved to ensure that the HR transition principles are applied and adhered to, and sets out the specific responsibilities of NHS and local authority employers.

It states that transfers of functions will be guided by the legal requirements of the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and/or Cabinet Office Statement of Practice on Staff Transfers in the Public Sector (COSOP) guidance, as appropriate. It should be noted that the Health and Social Care Bill contains general powers to effect TUPE-like transfer schemes.

The law relating to transfers is complex – each transfer is different and decisions are taken depending on the particular circumstances of the transfer. Each employer should take independent legal advice on these matters.

The Concordat is not intended to answer specific points about a particular detail of the transition and so some frequently asked questions have been developed to provide useful, practical answers and/or signposting. These FAQs will be regularly updated to keep the information available to staff and employers as fresh and as pertinent as possible.

The Concordat and FAQs are being followed by more detailed transition guidance, which is currently being developed for primary care trusts and local authorities as follows:

Primary Care Trust Transition Planning Guidance – this is being developed by the Department of Health for primary care trusts. This will be available in December 2011.

Local Government Transition Guidance – this is being developed by the LGA supported by NHS Employers and in consultation with local government and NHS union representatives. It is aimed at HR specialists in councils who will be managing the staff transfers. This will be available in January 2012.

These documents relate solely to the transfer of staff to local authorities. They do not relate to the transfer of staff and functions to Public Health England. This will be covered in the Public Health

England People Transition Policy, which will also be available in January 2012.

Sender guidance is also being developed by the Department of Health, providing practical advice, templates and guidance for sender organisations to implement the People Transition Policy(s) at local level. Items particularly relevant for primary care trusts and councils to use will be signposted.

These documents are designed to support primary care trusts, councils, trade unions and staff in the transition process. Any specific queries from employees about how the transfers affect them individually should be raised with their employer or trade union representative.

A Public Health Workforce Strategy will also be published in early 2012, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a future professional public health workforce for all sectors.

DH Department of Health

Produced: December 2011

Gateway reference: 17051

Produced by the Department of Health
www.dh.gov.uk/publications

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Department of Health

The new public health system: summary

What we are trying to achieve

We face significant challenges to the public's health and wellbeing. Rising levels of obesity, misuse of drugs and alcohol, high levels of sexually transmitted infections and continuing threats from infectious disease have a heavy cost in health, life expectancy and a large economic burden through costs to the NHS and lost productivity. Improving public health and wellbeing and developing sustainable services will be a key contribution to meeting the challenges to the public finances.

The Government has an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthy choices and changing the environment to support healthier lives. This document provides an overview of these changes and links to more detailed material to support implementation of the reforms.

In summary the reforms will see:

- local authorities taking the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote population health. Local political leadership will be central to making this work
- a new executive agency, Public Health England will:
  - deliver services (health protection, public health information and intelligence, and services for the public through social marketing and behavioural insight activities)
  - lead for public health (by encouraging transparency and accountability, building the evidence base, building relationships promoting public health)
  - support the development of the specialist and wider public health workforce (appointing Directors of Public Health with local authorities, supporting excellence in public health practice and bringing together the wider range of public health professionals)
- the NHS will continue to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts
- the Government's Chief Medical Officer will continue to provide independent advice to the Secretary of State for Health and the Government on the population's health
- within Government, the Department of Health will set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities.

The focus will be on outcomes. A new Public Health Outcomes Framework will set out key indicators of public health from the wider determinants of health through to effectiveness in reducing premature mortality. Our overall goals will be to increase healthy life expectancy and reduce health inequalities.

The Public Health Outcomes Framework will be published in January 2012 and will be aligned with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework.

Local responsibilities

Local authorities will have a new duty to promote the health of their population. They will also take on key functions in ensuring that robust plans are in place to protect the local population and in providing public health advice to NHS commissioners.

Through the health and wellbeing board they will lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public's health and wellbeing.

Giving local authorities this key role allows action to build on local knowledge and experience and aligns public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities.

To enable them to deliver these new public health functions local authorities will employ Directors of Public Health, who will occupy key leadership positions within the local authority.

The appointment process will be run jointly with Public Health England (on behalf of the Secretary of State for Health) to ensure that the best possible people are appointed to these key positions. Many local authorities have already made joint Director of Public Health appointments, and others are moving to take delegated responsibility for public health teams ahead of the statutory transfer of responsibility. We continue to encourage such action.

Real improvement will be secured by local authorities putting the public's health into their policies and decisions. However, they will also have responsibilities for commissioning specific public health services and will be supported with a ring-fenced public health grant.

While local authorities will be largely free to determine their own priorities and services, they will be required to provide a small number of mandatory services (sexual health services, NHS health checks, National Child Measurement Programme, providing public health advice to NHS Commissioners and ensuring plans are in place to protect the health of the public).

A ring-fenced public health grant will support local authorities in carrying out their new public health functions. We will make shadow allocations to local authorities for 2012/13 to help them prepare for taking on formal responsibility in 2013/14.

Shadow allocations for local authorities in 2012/13 will be published to support planning for the transition.

How does Public Health England fit in?

Public Health England will be created as a new integrated public health service. It will bring together the national health protection service and nationwide expertise across all three domains of public health. We are setting out the mission and values we expect Public Health England to deliver. Public Health England will be an advocate

for public health – its actions will be based on the highest professional and scientific standards and it will promote a culture of subsidiarity, focused on supporting local action, with national action only where it adds value.

Public Health England will have three key business functions:
1. It will deliver services to protect the public's health through a nationwide integrated health protection service, provide information and intelligence to support local public health services, and support the public in making healthier choices.
2. It will provide leadership to the public health delivery system, promoting transparency and accountability by publishing outcomes, building the evidence base, managing relationships with key partners, and supporting national and international policy and scientific development.
3. It will support the development of the public health workforce, jointly appointing local authority Directors of Public Health, supporting excellence in public health practice and providing a national voice for the profession.

Public Health England will bring together the wide range of public health specialists and bodies into one integrated public health service. Its organisational design will feature:
- a national office including national centres of expertise and hubs that work with the four sectors of the NHS commissioning board
- units that act in support of local authorities in their area
- a distributed network that allows Public Health England to benefit from locating its information and intelligence and quality assurance expertise alongside NHS and academic partners across the country.

Public Health England will be an executive agency of the Department of Health. It will have its own Chief Executive who will have operational independence.

Public Health England will have non-executive directors on its advisory board. The non-executives will support the Chief Executive in his/her role as accounting officer and provide an independent challenge. The Chief Medical Officer will provide independent advice to the Secretary of State for Health on the population's health and on the public health system as a whole, including Public Health England's role within it.

Public Health England's status will depend on its ability to provide high-quality, impartial, scientific and professional advice. To demonstrate its commitment to transparency and the highest professional standards, Public Health England will proactively publish its expert scientific and public health advice on relevant issues, and its advice to professionals and the public.

The NHS still has a role in public health

The NHS will continue to play a key role in improving and protecting the public's health. The provision of health services and ensuring fair access to those services will contribute to improving health and reducing inequalities.

The NHS will also continue to commission specific public health services and will seek to maximise the impact of the NHS in improving the health of the public, making every clinical contact count.

The NHS Future Forum is currently

considering how the NHS can contribute to improving the health of the public. Its interim findings have been published and are available.

The public health workforce

The success of the public health system will depend on harnessing the skills and energies of public health staff and on those staff building the effective relationships needed to make public health part of everyone's core business.

There is a diverse public health workforce, working for a wide range of employers. In managing the transition to the new system we need to ensure all staff are treated fairly and have access to the exciting opportunities to shape a 21st century public health service.

We are working closely with staff representatives and local government to ensure fair and transparent processes, and appropriate terms and conditions. We have published a Human Resources Concordat setting out key principles and will follow this with Local Government Transition Guidance and an initial People Transition Policy for Public Health England. The final People Transition Policy will follow formal agreement to the new terms and conditions.

Maintaining a vibrant professional public health workforce into the future will underpin the success of the reforms. The workforce strategy will be key to this and will be subject to specific consultation from January 2012.

Making it happen

Subject to the passage of the Health and Social Care Bill, these statutory changes will take place from 1 April 2013. Yet there is much that can be done to implement the reforms through local agreement before April 2013. We encourage all partners to engage actively in delivering the new systems and new ways of working in 2012/13.

There are a number of key milestones for the transition including:

- completion of transition plans for transfer of public health to local authorities – March 2012
- Public Health England's Chief Executive appointed – April 2012
- Public Health England structure agreed – May 2012
- pre-appointment processes complete – October 2012
- formal transfers of statutory responsibilities – 1 April 2013.

We will continue to develop our plans for the public health system in collaboration with our stakeholders and details will be published accordingly.

Stay in contact with our progress in establishing the new system at http://healthandcare.dh.gov.uk/category/public-health

DH Department of Health

Produced: December 2011
Gateway reference: 16912

NHS

Co-production for health: a new model for a radically new world

Building new approaches to delivery to achieve better health outcomes at the local level

FINAL REPORT
OF A NATIONAL
COLLOQUIUM
DECEMBER 2011

SPH Solutions for Public Health

directors of adass adult social services

Association of Directors of Public Health

Chartered Institute of Environmental Health

nhsalliance

Message of support for the Colloquium

The public health challenges we face as a nation – including from obesity, health inequalities and major health threats – demand a new approach. We need to reach out to communities with a locally led public health system that is underpinned by expertise and real political priority.

I'm delighted with the enthusiasm shown for this approach. There is a real commitment across local authorities and the public health profession to improve the health and wellbeing of our communities.

I am sorry that I cannot be with you today, but I am delighted to offer my support to an occasion that brings together so many of the leaders of the new system as you work to identify innovative approaches to better health.

The title of your event is absolutely right; the only way to deliver a successful transformation of public health is to bring together the full potential of local government, the NHS and our communities. Well done to everyone attending for their hard work, commitment and seeing this as an opportunity to change people's lives.

I wish you well and look forward to seeing your report.

ANNE MILTON,
PARLIAMENTARY UNDER-SECRETARY OF STATE FOR PUBLIC HEALTH

Executive Summary

A National Colloquium was held in November for an invited audience of public health, primary care, and local authority leaders. The summit considered how organisations could start to use the new arrangements for public health and commissioning positively at the local level to deliver better health outcomes and a reduction in health inequalities in the context of budget constraint. The Colloquium was organised by Solutions for Public Health (SPH) working with partner organisations, the Chartered Institute of Environmental Health (CIEH), the Association of Directors of Public Health (ADPH), the NHS Alliance and the Association of Directors of Adult Social Services (ADASS).

Discussion at the Colloquium focused on the necessary components of a new co-production model for public health, addressing the following questions:

- How to exploit the opportunities created by the integration of public health and local government?
- How to maximise the new structures, approaches and democratic accountabilities to deliver public health outcomes and a reduction in inequalities?

And drawing out contributions on leveraging the transition to:

1. Maximise the new commissioning structures to improve health outcomes and reduce inequalities when money is tight
2. Establish what is needed to deliver evidence informed decision making for public health
3. Use the new partnership opportunities to do things better
4. Maximise leadership roles in the new system

Key messages

The key messages emerging from the discussions during the day were:

- Use the transition to start to develop a new co-production model for health and wellbeing.
- The model will fail without elected members' understanding and buy-in – they need to be at the helm.
- Establish focused, agreed priorities which have meaningful outcomes for all partners.
- Put in place a mechanism and infrastructure to ensure effective delivery.
- Use intelligence dynamically, creatively and succinctly and in relevant forms for different audiences.
- Promote an asset based approach to communities to understand and harness their assets and resource.
- Adopt a new approach to partnership and leadership whilst building on what has worked.
- The public health workforce has to change – a new business model needs adopting that is pragmatic, practical and delivers solutions to commissioners and providers.
- Build public health capacity across a whole range of workforces to deliver interventions at industrial scale.

Necessity is the mother of all invention – creatively delivering change together

Health inequalities are widening and there is a shared need to address the social gradient for health in new ways if public sector and other providers of health and wellbeing services are not to become swamped and unaffordable. National policy direction and public sector reform have created a new dynamic at the local level to enable stakeholder organisations to review how improved health, in its widest sense, can be delivered with more efficient, more equitable and more sustainable outcomes, all in the context of less available funding. In many parts of the country, work is underway, in a variety of sectors – local councils, communities, voluntary sector, public health teams, health services, clinical commissioning groups – to test ways, using the new levers and changes in the system positively and creatively, to achieve change.

"The imperative is to move together now to a new model – act now and do what you can!"

Solutions for Public Health (SPH), with its Colloquium partners, the Chartered Institute of Environmental Health (CIEH), the Association of Directors of Public Health (ADPH), the NHS Alliance and the Association of Directors of Adult Social Services (ADASS) saw merit in bringing together thought leaders, from different sectors around the country, to tackle these issues, share experiences of the new ways of working and explore ideas for what will work in the new world (see Appendix 2 for full list of delegates).

There was consensus across the agencies of the benefits of taking a holistic approach to delivery of health outcomes at the local level and what is needed to be in place to make this happen. Local Government is the place to orchestrate partnerships to drive health and wellbeing. This is a given. There are benefits for individual's health, for community engagement, capital and capacity and for partner organisations to deliver shared outcomes, offsetting demand and cost.

This report is issued to stimulate further thought and ideas, help clarify objectives for local leaders and shape action in new ways whilst organisations are still in transition and options for delivery of new systems are still being considered.

Setting the context – The widening gap

A radical new approach is essential because of widening health inequalities in the context of much less funding in the public sector. Dr Mike Grady from the Marmot team set the context.

The Marmot Review (Fair Society, Healthy Lives[1]) highlighted a 17-year difference in disability free life expectancy in England between those at the bottom of and those at the top. It is estimated that two thirds of people aged 68 and over will have a life-limiting illness in the future.

1 Marmot M. (2010) Fair Society,Healthy Lives: Strategic Review of Health Inequalities in England post 2010. The Marmot Review, 11 February 2010

"A radical joined-up approach with give and take from all stakeholders is the only way forward."

Just targeting policy effort on those in the bottom tier will not be sufficient to shift the steepness of this gradient. Actions must be universal but with an intensity and scale that is proportionate to the level of disadvantage (proportionate universalism). One way forward is to take a life course approach. Economic disadvantages are reinforced from one generation to the next. For example, educational opportunities impact on later life chances in personal wealth and health status. We need to work on accessing key stages across life, starting with children and those arriving at school less able to benefit from education. Equally, unless action is taken with those aged 16–24, there will be a lost generation who do not work, and will not know how to.

There is growing evidence that, if you engage with people in disadvantaged communities to take control, their self esteem, confidence and health and wellbeing improves and, thereby, their ability to change their life style. To do this effectively they need to be at the top of their game.

A number of Health and Wellbeing Boards are using the 6 Marmot policy objectives to drive their Health and Well being Strategies:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

"We must use Marmot as the compass to guide our health and well being strategies."

The Marmot Review confirmed the Wanless[2] findings that the health service will be unaffordable in 20 years unless fully engaged communities are achieved, and are empowered. Local government is the place to orchestrate partnerships to drive health.

It is even more important in a recession that we have a focus on health, wellbeing and resilience. If we do not, public services will be overwhelmed with demand. Individuals need to be empowered as individuals and communities to support each other and complement whole system work. This is not the same as just saying people have to take personal responsibility. The task for local policy makers, commissioners and local stakeholders is to create the conditions in which they can do this.

2 Securing Our Future Health: Taking a Long-Term View. The Wanless Report, DH, 1 January 2002; Securing Good health for the Whole Population. Final Report, HM Treasury, 25 February 2004

Using the transition to start to develop a new co-production model for health and wellbeing

Creating a functioning co-production model based on social justice and with a revamped approach to the public health workforce means ditching the silo/single organisation focus with individual funding streams from the past. We must move to create a stronger shared, broader focus on health for the future. Organisations can use the transition now to establish the building blocks for this.

1. FOCUSED, AGREED PRIORITIES WHICH HAVE MEANINGFUL OUTCOMES FOR ALL PARTNERS

An early step is to establish, locally, shared priorities across all partners on the Health and Wellbeing Board that will make a difference to overall health outcomes. This will also assist each partner organisation in achieving their own objectives including financial savings. Alcohol misuse is a good example because of the adverse impact it has on the environment, communities, employment, excess hospital admissions. The Marmot approach to intervention at key stages in the life course is also a potential unifying way forward.

The trick is to create policy direction all partners can support, see the place of their particular contribution and how collective engagement will bring better outcomes across the whole population. There is an economic as well as an epidemiological case to be made.

Locally, key partners need to be identified and, in county council areas, mechanisms for securing effective engagement with district councils. Boards need to be clear on the appropriate geographical level to get decision making right – and the right partners on board at each level. What is best looked at once over a large population (economies of scale and avoidance of duplication) versus what will bring greatest dividends by being done at the very local, neighbourhood level.

"Integration does not just mean click and drag!"

2. DELIVERY MECHANISMS IN PLACE

There needs to be a mechanism and infrastructure beneath Health and Wellbeing Boards to ensure follow through of effective delivery. This might include task and finish groups with members well versed on specific issues so that they can take informed cabinet decisions. Consistent evaluation, monitoring and performance management of all contracts and programmes will be key.

3. USING INTELLIGENCE INTELLIGENTLY

An aide to shared understanding is relevant information and evidence of what works. The Joint Strategic Needs Assessment (JSNA) is a well established source of information but the intelligence within it is not always presented in ways that are timely, easily digestible or

"Communities are a key resource. Let's actively engage with them to harness their potential for driving the change."

relevant to the audiences who need to use it. Moreover, JSNAs currently do not always access the wealth of data available at the local level. JSNAs of the future need to link with intelligence held, for example, by the fire and police services as well as the whole range of local government departments. Insufficient use has also been made of the wealth of qualitative intelligence held within neighbourhoods and communities.

Intelligence has to be used dynamically, creatively, succinctly and in relevant forms for different audiences. The move of NHS public health teams into local authorities can help with translation of intelligence from a range of sources but only if they adopt a different approach which is perceived as less academic, more pragmatic and focused on practical solutions.

4. AN ASSET-BASED APPROACH TO COMMUNITIES

If communities, and individuals within communities, are to be empowered they need to feel they are shaping their own futures. Local authorities already have extensive networks with communities. We need to use communities positively to understand and harness their assets and resource, particularly around personalisation of budgets. There is also much statutory bodies can learn from the approach of the voluntary sector in securing effective local engagement.

5. NEW FUNDING MECHANISMS TO DRIVE CHANGE

There is no point in spending public money on what does not work. Not only is this wasteful, it does not deliver the best outcomes. There simply is not the funding to do this in the future. Health and Wellbeing Board partners will need supporting evidence of:

- where investment in agreed priority areas will make a difference to health outcomes when, modelled in the short, medium and longer term;
- where and when savings realistically can be achieved when modelled in the short, medium and longer term;
- long term impact on the health of populations of the downsizing of budgets.

This could entail pooling arrangements, refocusing existing budgets, disinvesting or the decommissioning of services. Creating cogent narratives around this which are meaningful to all partners and the public will be crucial to successful implementation. Aligning strategy to on-the-ground commissioning and project work is essential as is securing partner commitment to deliver change through commissioning and providing arrangements.

Providing boards and partners with ready access to public health skills will ensure evidence is tailored to local situations and leads to pragmatic decision making. Decision makers need to know the strength of evidence about what works but also advice on how to proceed where current evidence is weak.

6. THE MODEL WILL FAIL WITHOUT ELECTED MEMBERS' UNDERSTANDING AND BUY-IN

"Every councillor could be a local advocate for health."

All are agreed that the new arrangements will only work if elected members are fully on board and committed. They are in the driving seat. The reforms present an opportunity to secure their engagement in more productive ways and create new champions for health and wellbeing. Local councillors are, after all, in touch with local communities, know and understand local issues and the local economy, and what can realistically be done. The new arrangements bring opportunities for forging closer links between GPs and members and between the public health workforce and members. Once again, it is crucial to create relevant narratives and understanding for members about how, through effective use of new powers and duties in councils, they can make a real difference to health and wellbeing. Members also have key links into commerce and the business sector, another fruitful area for engagement for health, especially in improving health in the workplace.

7. A NEW PARTNERSHIP AND LEADERSHIP MODEL

We need a new approach to partnership and leadership to make this work whilst retaining useful existing assets (for example from the Local Strategic Partnerships) where they have worked. If local change is to be delivered, partners will need to support each other in implementing difficult decisions. There is interdependency, a need for mutual support and a readiness to share for the public good. There is a need to share accountability for decisions taken together at the strategic level as well as in the context of good risk management and building in contingencies. This is particularly important during the transition when organisations must continue delivery but, at the same time, put new arrangements in place. Health protection arrangements are one example where the local system for the future is not yet fully clear but where there is a key need for local organisations to work together now in the transition to manage risk. Organisations will need also to ensure risk can be managed safely to allow new developments to be tested and implemented.

There are new leaders for health in the system and new opportunities for joint working such as GPs with Adult Social Care over service redesign and balancing commissioned programmes with personalised budgets. Partners are currently at different stages in the development process. This needs to be recognised.

The Director of Public Health (DPH) has a key part to play in facilitating a new style of leadership and empowering others to take on leadership roles for health. The traditional model of a Director of Public Health as the sole advocate and champion for health must be consigned to the past. We need a new conceptual model for the new environment with the DPH working corporately alongside their colleagues in the local authority. Support should be in place to help those who wish it in adapting to this new style of leadership.

8. THE PUBLIC HEALTH WORKFORCE HAS TO CHANGE

We need a radically new approach to the public health workforce that gets beyond the view that only those who are fully trained can deliver public health. It will also need to refocus the work currently delivered by those that are already trained. Placing NHS public health teams within local government is not "click and drag".

We need to start with a new business model for public health which is based on how technical and leadership skills can assist and add value to councils and CCGs in delivering their outcomes but in different ways. The language and approach need to change. The skills in translating complex information and evidence into meaningful recommendations need honing. Local commissioners need pragmatic solutions based on the best evidence available. They need to know the implications and impact of different commissioning decisions.

Public health professionals have been accused of being too purist. Decisions for the future must be practically based. Public Health may well be an advocate for health but it also needs to be seen as a service to commissioning functions rather than an empires in its own right. It does mean a change in style to one that is more facilitative and one which seeks outcome delivery through others. These are new roles and ways of working and people will need help and support in adapting to them.

9. BUILDING PUBLIC HEALTH CAPACITY ON AN INDUSTRIAL LEVEL SCALE

The new opportunities presented are considerable, not least in being able to engage with and work closely with a range of departments in local government and, through new duties to be placed on local authorities, with CCGs.

Achieving public health outcomes cannot rest with a relatively small professional specialist and practitioner public health workforce. A key advantage of the changes will be the ability to foster closer working with, and active engagement from, public health practitioners in the local government and primary care workforces such as environmental health officers, pharmacists and health visitors.

To make the new model work many more people need to have core public health skills and an awareness of public health whether it is the social or health care workforce, those working in housing, leisure and planning or in the voluntary sector and communities. There are examples now round the country where mandated basic training in health is delivering benefits in early referrals to services. "Every contact counts" needs to be the mantra for all providers of health and social care. This will not happen without a focused local strategy, investment and development.

Conclusions

We firmly believe co-production is the best way to deliver better health and wellbeing outcomes at the local level in a tough financial climate. We are not claiming it is easy to do and we do not as yet have all the answers, particularly about future interfaces between some new structures at the supra-local level. Enough is known, however, to start the ground work in relationship building, shared priority setting and changing the way organisations at the local level work together, harness available assets together, and behave towards each other.

A co-production model presents the best use of available expertise and new commissioning and partnership arrangements. The take-away headlines for organisations from the day were:

- Don't wait. Act now on what you know already and what you can do.
- Start with building local relationships.
- The Marmot Review is more relevant than ever. Use the six Marmot policy objectives as the foundation for strategic partnership working.
- Take a positive asset based approach to engage with and work with communities using them as a resource and source of qualitative intelligence and evaluation of what works.
- Develop a new local model and business case for public health, ensure roles and expertise are in line with outcomes needed and maximise contributions from all stakeholders.
- Be flexible in approach – one size will not fit all.
- Maximise new levers in the system to create something different and use the Health and Wellbeing Board to move from a silo approach to strategy and implementation.

Partner Perspectives:

SPH – Change is happening. Public Health is an essential multidisciplinary discipline which can make a substantial contribution, using technical skills and leadership qualities to reducing health inequalities and improving health. To do this, however, it needs to embrace change positively and adapt its skill base and leadership approach to fit with new challenges and circumstances.

NHS Alliance – The Alliance is committed to general practice commissioning and for GPs to take more responsibility for improving the cost effectiveness of the NHS. Unless everyone – frontline staff, local communities – is fully engaged, it is clear that health outcomes will not improve to the extent needed. Equally, if local authorities are not fully on board with the health agenda, there will be no short term gains to offset the longer term return on investment in health improvement. Clinical Commissioning Groups (CCGs) will need to connect with public health, local authorities and their local populations. Public health, in particular, needs to be clear on its offer to CCGs who will need help with the authorisation process. The focus is on building relationships at the local level.

A key change is to move to a co-production model, building on local assets and empowering people to engage on health. Statutory organisations will not be able to deliver public health outcomes on their own so who else is out there ready and willing to help; how can we build local networks and use front line workers to support them? The stakeholder approach in this model should be "how can I help you with your outcomes?" not just "how can you help me with my outcomes". This will need a new style of facilitative leadership.

ADPH – The Association is positive about moving public health into local government. There is still work to be done in making a whole new system work, linking Public Health England with the role of Directors of Public Health and teams in local government and supporting Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board to maximise scarce resources and avoid duplication. New arrangements will mean public health teams working in new ways to seize opportunities, working with local authority members and officers. A key focus will be to ensure those who are further on in the process help those who are at the start of transition – learning the lessons, providing support.

ADASS – Local authorities are about commissioning and shaping not providing. They also have experience in decommissioning and moving services into communities. These skills are valuable to colleagues working in the health service.

A plea, however, not to get bogged down in process but look at the real strength in doing things differently together. There are many natural allies of public health within local authorities beyond environmental health – the Director of Adult Social Services, for example, shares common ground in addressing inequalities and community needs but other allies in terms of their potential impact on health are housing, children's services, planning, leisure, so use them. Local authorities are positive about the changes but not clear about the whole landscape and may need help in understanding this. Local authorities have a strong tradition of engaging with individuals and communities. Parish councils can also make a contribution. What is needed is alignment of outcomes.

Local authorities are, however, not alike. They differ in size, shape, political complexion. There needs to be an element of pragmatism about what works best locally. The new world of public health will, therefore, be political. A key need is to understand fully the funding envelop and opportunities that will exist between local government and public health jointly to deliver the offer.

CIEH – The step change we need in public health delivery will only happen if we do it together and if it is linked to a social justice agenda. The Health and Well Being Board will be the cockpit for making decisions in partnership with CCGs. Individual organisational budgets will be insufficient to make a difference. We need to add the public health ring-fenced budget to what NHS and local government are already doing, drawing in outside organisations, to blend resource use to improve health outcomes.

We should not forget the complexity of two-tier arrangements with one third of the country covered by county councils. The biggest workforce for environmental health is in the districts. They are ready and willing to be engaged.

Appendix

1) THE PRESENTATIONS AND VIDEO FOOTAGE

You can view some of the highlight presentations at **www.sph.nhs.uk/lgcolloquium**

Marmot Review: Opportunities to reduce inequalities in the new public health context – presented by Dr Mike Grady
Download presentation at **www.sph.nhs.uk/m_grady.pdf**

Politics, people and places: England's new public health services from April 2013 – presented by David Kidney
Download presentation at **www.sph.nhs.uk/d_kidney.pdf**

Using the new commissioning structures to improve health and reduce inequalities when money is tight – presented by Dr Chris Packham
Download presentation at **www.sph.nhs.uk/c_packham.pdf**

Wigan: Healthy Lives, Healthy People? Making Marmot Real for Real People – Intelligence led Decision-Making – presented by Dr Kate Ardern
Download presentation at **www.sph.nhs.uk/k_ardern.pdf**

Public Health & Local Government: An ADASS Perspective – presented by Glyn Jones
Download presentation at **www.sph.nhs.uk/g_jones.pdf**

Maximising the Leadership Role of the DPH – presented by Jim McManus
Download presentation at **www.sph.nhs.uk/j_mcmanus.pdf**

Co-Production of (Public) Health – presented by Professor Chris Drinkwater
Download presentation at **www.sph.nhs.uk/c_drinkwater.pdf**

2) WORKSHOP ATTENDEES

Chair:	Alison Hill, Solutions for Public Health (NHS)
Speakers:	Dr Mike Grady, Senior Research Fellow, Marmot Review Team
	David Kidney, Head of Policy, Chartered Institute of Environmental Health
	Dr Chris Packham, National Clinical Commissioning Lead, RCGP Centre for Commissioning
	Dr Kate Ardern, Executive Director of Public Health, Borough of Wigan
	Glyn Jones, Public Health Lead, Association of Directors of Adult Social Services
	Jim McManus, Joint Director of Public Health, Birmingham City Council & Birmingham PCTs
	Professor Chris Drinkwater, President and Public Health Lead, NHS Alliance

Delegates:

Frank Atherton	Association of Directors of Public Health
Michael Attwood	SPH Associate
Susan Biddle	Local Government Improvement and Development (LGID)
Karen Bollan	Independent
Jean Bradlow	Independent
Kim Carey	Cornwall Council
Paul Clark	Harrow Council
Councillor Michael Cooke	Leicester City Council
Jake Eliot	National Housing Federation
Karen Foster	Solutions for Public Health (NHS)
Nick Georgiou	Solutions for Public Health (NHS)
Ian Gray	Chartered Institute of Environmental health
Dr Nicholas Hicks	NHS Milton Keynes
Paul Jennings	NHS West Midlands
Ian Kedge	Lewes District Council
Kate Kennally	London Borough of Barnet
Rita Lally	Buckinghamshire County Council
Jane Leaman	Freelance
Tony Macklin	Port Health & Public Protection Service
Ms Janet Maxwell	NHS Berkshire West
Alyson Morley	Local Government Group
Steve Miller	Newham Council
Nick Raper	Outcomes UK
Don Sinclair	Solutions for Public Health (NHS)
Chris Spencer	SPH Associate
Nicola Stevenson	NHS Confederation
Janice Steed	LeaderShape
Marcie Taylor	Nottinghamshire County Council
Clare Vollum	Age UK
Steven Wibberley	Macmillan Cancer Support
John Wilderspin	Department for Health
Colin Williams	Newcastle City Council
Jenny Wright	Solutions for Public Health (NHS)

integration

"Integration does not just mean click and drag!"

click and drag

An electronic copy of this report can be found at: **www.sph.nhs.uk/lgcolloquiumreport**

Order your free hard copy by emailing **solutions@sph.nhs.uk** or writing to:

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Association of Directors of Public Health

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nhsalliance

Department of Health

Public Health England's Operating Model

Factsheets

Department of Health

Mission and values

From its establishment in April 2013, Public Health England will be the authoritative national voice and expert service provider for public health.

Mission

Public Health England's overall mission will be to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes.

It will do this in concert with the wider health and social care and public health system, and with key delivery partners including local government, the NHS, and Police and Crime Commissioners, providing expert advice and services and showing national leadership for the public health system.

Purpose

Public Health England will work with partners across the public health system and in wider society to:

- deliver, support and enable improvements in health and wellbeing in the areas set out in the Public Health Outcomes Framework
- lead on the design, delivery and maintenance of systems to protect the population against existing and future threats to health.

Role

Public Health England will work with its partners to provide expert evidence and intelligence, and the cost-benefit analysis that will enable local government, the NHS, and the voluntary, community and social enterprise sector, among others, to:

- invest effectively in prevention and health promotion so that people can live healthier lives and there is reduced demand on health and social care services, as well as on the criminal justice system
- protect the public by providing a comprehensive range of health protection services
- commission and deliver safe and effective healthcare services and public health programmes across the whole lifecourse and across care pathways; from prevention through to treatment, from children's services to mental health and wellbeing, substance misuse services, screening programmes and older people's services
- ensure interventions and services are designed and implemented in ways that meet the needs of different groups in society advancing equality of opportunity between protected groups[1] and others, and reducing inequalities.

A transformed public health system will rely on a strong and capable workforce, building on the core professionalism and high standards of current practice while working in new ways and with new partners. Public Health England will work with partners to ensure the effective supply and deployment of a qualified and expert workforce across the system and to provide professional support for those working in public health specialisms.

The organisation will harness its experience, intelligence and evidence base to promote transparency and improvement in performance across the public health system, and to provide impartial and expert advice to policy makers across Government on the best operational means to achieve public health goals.

Ways of working

Working with local government

The transformed public health system will be built on local action. Local authorities, supported by their Directors of Public Health, are the local leaders for public health. Public Health England will not duplicate the work that they do. Instead, Public Health England will be the expert body with the specialist skills to support the system as a whole. Public Health England will carry out functions and activities that would not be practicable to replicate in each local authority. Public Health England will support local authorities in their new role by providing services, expertise, information and advice in a way that is responsive to local needs. It will support local authorities to ensure action taken is on the basis of best available evidence of what works.

Working with the NHS Commissioning Board

Public Health England will provide a public health service to the NHS Commissioning Board to support the commissioning and delivery of health and wellbeing services and programmes. Public Health England will be providing public health and population healthcare advice to the NHS Commissioning Board. It will work with the NHS Commissioning Board to ensure that the prevention of ill health and promotion of good physical and mental health and wellbeing are addressed systematically across services and care pathways.

As recommended by the NHS Future Forum in its November 2011 interim letter, further work will be done in 2012 to establish and publish the arrangements of how Public Health England and the NHS Commissioning Board will work together. This will set out how NHS commissioners can obtain population health advice from Public Heath England and how both organisations will be accountable for performing their roles effectively and in partnership.

Working with Government

Public Health England will be an executive agency of the Department of Health, and its Chief Executive will be accountable, both to the Permanent Secretary and the Secretary of State for Health, for its performance and strategic development. This operational independence will allow Public Health England to provide impartial, evidence-based information to Government departments, and support the Chief Medical Officer in providing cross-Government public health advice.

Working with the devolved administrations

Public Health England will be able to coordinate nationwide action where necessary, including working with the devolved administrations to tackle nationwide threats to health from infectious disease, radiation, chemicals and other health hazards, and to enable effective UK-wide emergency preparedness, resilience and response arrangements.

Working with expert partners worldwide

Existing and emerging challenges to health need innovation and an increasingly global approach. Public Health England will:
- work with partners in academia and across the public health system in the UK and internationally to identify, understand and develop approaches to tackling new and emerging threats to health
- have a strong practical focus on fostering innovation, and on evaluating and disseminating effective practice from learning across the system to protect and improve health
- develop and draw on new behavioural science techniques, and use these to implement new approaches to support the public to make healthier choices
- work in strong partnership with the public health workforce.

Functions

Public Health England will achieve its aims through a wide range of activities, working with partners across and beyond the public health system. Public Health England will have three main business functions:
1. Delivering services to national and local government, the NHS and the public.
2. Leading for public health.
3. Supporting the development of the specialist and wider public health workforce.

Culture and values

Public Health England will need to develop its culture and values, and the Chief Executive designate and senior team will lead this process during the transition to the new organisation in 2012/13.

Public Health England will demonstrate:
- advocacy for public health, across all of its work for quality improvements and greater positive population health effects of healthcare and social care services
- a culture of subsidiarity, focused on support for local accountability and action and commitment to adding genuine value through its nationwide activity
- clear focus on its goals of improving and protecting health and wellbeing, and reducing inequalities
- commitment to open, respectful and constructive partnership working across the public health system, recognising and valuing the roles and expertise of others
- scientific and analytical rigour, dedicated to providing impartial and objective advice, evidence and expert judgement and taking action on the basis of the best available evidence
- a forward-looking, flexible and innovative approach, constantly seeking to develop new ways of tackling challenges, and harnessing learning from different sectors and countries
- transparency and accountability in the way it delivers all its functions
- valuing its people, with an inclusive culture and commitment to equality and to fair opportunities for all to progress
- strong financial discipline, with value for money and cost-benefit analysis at the heart of its services and operations, and commercial expertise to enable generation of income from its activities where appropriate, to offset the costs of its operations.

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[1] There are nine protected groups in Equalities and Human Rights Legislation. These are age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Department of Health

Functions

Public Health England will carry out nationwide and specialist functions for public health. Locally public health will be led by local authorities.

Functions

Public Health England's three main functions will be:
1. Delivering services to national and local government, the NHS and the public.
2. Leading for public health.
3. Supporting the development of the specialist and wider public health workforce.

Function 1: Delivering services

Public Health England will:
- deliver specialist public health services to national and local government, the NHS and the public, working in partnership to protect the public against infectious diseases, minimise the health impact from hazards, and provide national leadership and coordination of the public health response to the emergency preparedness, resilience and response system[1]
- deliver an information and intelligence service to support effective action, locally and nationally, to promote and protect health and wellbeing, prevent illness, advance equality, tackle inequalities and improve public health outcomes
- support the commissioning and delivery of effective health and care services and public health programmes by the NHS and local authorities through public health advice, analysis, service specifications, evidence and best practice dissemination, as appropriate
- design and deliver nationwide communications and interventions to support the public to protect and improve their health, including use of social marketing and behavioural insight techniques.

Function 2: Leading for public health

Public Health England's second function covers activities across the whole public health system and supports health ministers, the Department of Health and the Chief Medical Officer in working across government on public health issues.

Public Health England will:
- encourage transparency and accountability across the system by publishing information on local and national health and wellbeing outcomes, and supporting improvement action
- support public health policy development through evidence and advice on the best operational means to achieve strategic goals
- allocate and deploy its budget and manage relationships effectively to support effective and integrated public health delivery across the system
- work with partners to build the evidence base from research and experience about what works in improving and protecting health and wellbeing; narrowing health

inequalities and advancing equality; and promote and evaluate innovation
• act for public health science and delivery on the international stage.

Function 3: Developing the workforce

Public Health England will support the development of the specialist and wider public health workforce.

Corporate activities

Public Health England will need to prove itself as a high-performing organisation and make efficient and effective use of all its resources to deliver high performance and value for money.

To deliver this, Public Health England will need a range of strong corporate, business support and development functions to support its activities and staff, including business development functions to harness opportunities for generating external income.

Where corporate services can be delivered more effectively and efficiently Public Health England will pursue shared services.

Public Health England will be able to secure income from the sources currently open to the organisations coming into it, and will provide services to the private sector as customers.

This will provide income to fund public health action, foster best practice, promote innovation, ensure efficient and cost-effective operations and help to sustain critical mass of expertise to support innovation and attract research funding.

[1] More work will take place in the coming months to develop operational guidance for the system-wide emergency preparedness, resilience and response model, including exploring how Public Health England and local government will work together to protect the health of local populations.

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Gateway reference: 16912

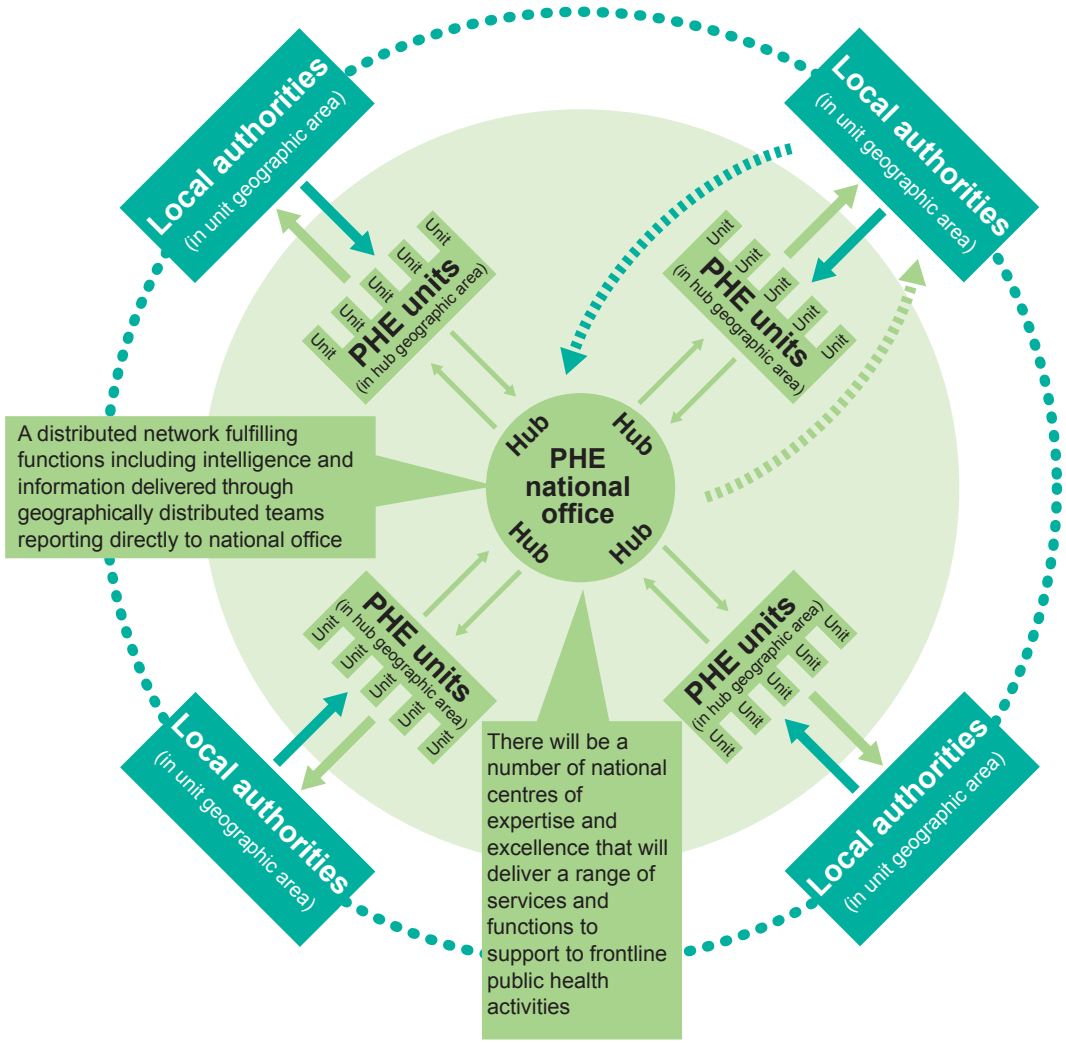
Department of Health

Organisational design

The Chief Executive designate for Public Health England will lead work on the organisation's full design in 2012/13.

We expect Public Health England's structure will have three elements:
1. A national office including national centres of expertise and four hubs that oversee its locally facing services.
2. Units that deliver its locally facing services and act in support of local authorities, other organisations and the public in their area.
3. A distributed network for some functions including information and intelligence, and quality assurance functions, to allow them to be located alongside the NHS and academic partners.

The diagram below provides an overview of how each of these elements of Public Health England's structure will fit together.



National office

Public Health England's senior management team will be based in a national office. The national office will act as the service centre for the organisation and provide national leadership, strategic direction and support the overall integration and coordination of the public health system.

The national activities will also include national centres of expertise and excellence for public health and four hubs that will oversee the delivery of its locally facing services.

National centres of expertise and excellence

The current public health system relies on a number of centres that concentrate professional, scientific and analytical expertise in order to deliver a range of services and functions to support frontline public health activities.

Public Health England will build on current arrangements to develop the centres of excellence to support its work across all the domains of public health, ensuring that all parts of the new public health system, partner organisations and the devolved administrations benefit from the centres' expertise.

Hubs

The effective delivery of some Public Health England functions will rely on the leadership and coordination of the work of its units and their partners in the local public health delivery system.

This could not be carried out effectively from a single national office. So Public Health England will distribute a small number of national office functions across geographical hubs, which will be part of the national office and act within a national framework. There will be four hubs that are coterminous with the four sectors of the NHS Commissioning Board and Department for Communities and Local Government resilience hubs, covering London, the South of England, Midlands and East of England and North of England.

For each of these areas the hubs will:

- ensure that Public Health England's emergency preparedness, resilience and response plans are in place
- ensure that high-quality public health and healthcare advice, including for screening, immunisation and specialised services commissioning, is available to the NHS Commissioning Board
- assure the quality and consistency of all services delivered by the units, ensuring that they are responsive to local government
- support transparency and accountability across the system, including managing strategic discussions with partners in relation to achievement of public health outcomes
- offer professional support to Directors of Public Health in local authorities.

Units

Directors of Public Health are the local leaders for public health and provide a core offer to the NHS. Alongside this, Public Health England will deploy expert and specialist advice capacity at a level that allows it to understand and respond to local needs and support local leaders

to tackle the challenges they face. When appropriate, units will provide coordination across several local authorities in managing incidents and outbreaks.

Public Health England's units will develop from the 25 current health protection units of the Health Protection Agency. The units' main areas of work will be to:

- deliver services and advice to local government, the NHS, other local organisations and the public, and work in partnership to protect the public against infectious diseases, minimise the health impact from hazards, involving the national centres when appropriate
- make an effective contribution to the emergency preparedness, resilience and response system
- support effective local action to promote and protect health and wellbeing and tackle inequalities, including through providing or facilitating access to data and intelligence and evidence on best practice.

Further work on units' design

Early in 2012 we will be seeking the views of local authorities, health and wellbeing board early implementers and local partners on how Public Health England can best prove its responsiveness and expert contribution to localities.

We will be keen to consider how:

1. Public Health England might contribute information and advice to the independent report of the Director of Public Health.
2. Directors of Public Health and Public Health England can work together to determine the contribution of Public Health England to health and wellbeing boards.
3. Public Health England should organise its working relationships with NHS clinical commissioning groups, clinical senates and providers.
4. The annual work programme for Public Health England can best be informed by:
   - locally specific and relevant indicators
   - any 'cross-local authority' priorities that have been identified as being delivered more effectively in a collaborative way
   - national priorities as expressed in the various outcomes frameworks
   - national priorities set by Government.

A distributed network

Some of Public Health England's functions, including its quality assurance and information and intelligence functions, will be repeated and consistent across the country but dependent on strong local relationships.

Some national functions will be provided through geographically distributed arms of Public Health England that are accountable to the national office.

Others will be replicated in a consistent fashion across the country and focus on supporting the interpretation and use of information and intelligence by the local public health system.

Detailed assessment of the case and leadership for replicated functions is under way.

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Gateway reference: 16912

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Status and accountability

Status

Public Health England will be an executive agency of the Department of Health, and will have the operational autonomy to advise Government, local authorities and the NHS in a professionally independent manner.

Public Health England will operate transparently and will provide Government, public health professionals and the public with expert, evidence-based information and advice.

As an executive agency it will be operationally independent. It will demonstrate its transparency through:
- developing its strategic plans through open challenge and review, involving local government, the NHS and the public
- reporting openly on its level of achievement against the specific performance measures set by Government, and on its contribution to the achievement of improvements against the Public Health Outcomes Framework
- proactively publishing its expert scientific and public health advice on relevant issues and its advice to professionals and the public.

Accountability

When Public Health England is established in April 2013, its Chief Executive will:
- be responsible for the day-to-day operations of Public Health England, including responsibility for delivering its services to a high level
- be the Accounting Officer for the agency, and ensure that processes are in place to ensure the appropriate use of public funds
- report to the Permanent Secretary of the Department of Health.

The Secretary of State for Health will remain ultimately responsible to Parliament for the delivery of the functions for which Public Health England is responsible.

In addition to the reporting structure through the Permanent Secretary, the Chief Executive will be accountable to the Secretary of State for Health and they will meet at least annually to discuss the performance and strategic development of Public Health England.

Governance

The Chief Executive will establish an advisory board to provide external challenge and expertise. This will advise on the running and ongoing development of Public Health England.

Our current intention is that the Chief Executive will chair the Board, which will include at least three non-executive members who will provide independent advice and support.

We expect the non-executive members will

have relevant experience in public health, local government and the voluntary and community or private sector in order to provide a broad range of experience and challenge.

One of the non-executive directors will also chair the agency's audit and risk committee.

The Department of Health will set the legal and policy framework, and secure resources for the public health system, including Public Health England.

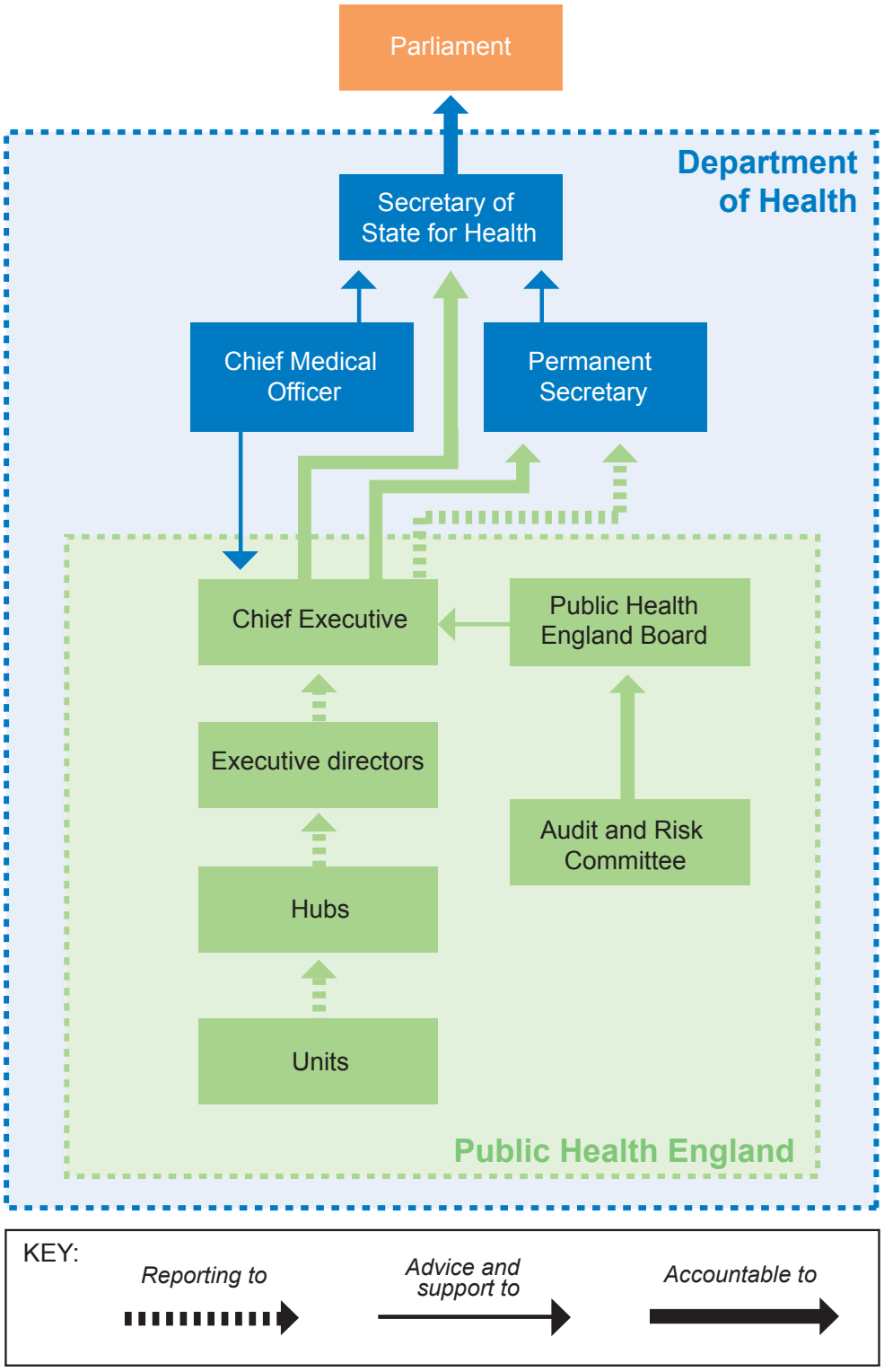
The Permanent Secretary will appoint a Departmental Sponsor for Public Health England who will provide the day-to-day contact between the Department of Health and the agency.

The Government's Chief Medical Officer will continue to provide independent advice to the Secretary of State for Health and the Government on the population's health.

The Chief Medical Officer will be supported in this role by a Public Health Advisory Forum. This will bring together expert professionals and leading partners to assist the Chief Medical Officer in providing quality advice and challenge on public health policy and implementation, including areas such as the Public Health Outcomes Framework.

The diagram shown on the following page sets out the accountability and governance structure for Public Health England that will support its operational freedom.

We will continue to listen closely to the views of stakeholders as we develop our detailed plans for Public Health England.



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Next steps – establishing Public Health England

Appointing Public Health England's leadership team

Getting the right people to lead the new Public Health England is critical and the work to establish Public Health England begins now.

We expect to appoint a Chief Executive designate in April 2012 in advance of the organisation starting its operations to manage the transition process, and to further develop and implement the operating model for Public Health England through 2012/13.

The Chief Executive designate will then wish to appoint the senior team.

Transition plans for the Public Health England workforce

We have identified approximately 5,000 highly trained and dedicated members of staff within the existing organisations and functions that will transfer across into Public Health England in April 2013. We will negotiate specific terms and conditions that meet the Civil Service Code[1] but retain the flexibilities from NHS terms and conditions.

The expertise and professionalism of this workforce will prove a valuable asset for Public Health England.

Staff from a range of specialist organisations are coming together to form Public Health England:

- Health Protection Agency staff including scientists, doctors, nurses, technicians, emergency planners, analysts and administrators, who identify and respond to health hazards and emergencies caused by infectious disease, hazardous chemicals, poisons or radiation
- National Treatment Agency for Substance Misuse staff including clinicians, analysts and experienced drug treatment workers and commissioners from a variety of backgrounds across the health, social care, criminal justice and substance misuse fields, who improve the availability, capacity and effectiveness of drug treatment in England
- Department of Health staff, including public health practitioners, whose functions are expected to transfer to Public Health England
- public health staff working in strategic health authorities who currently lead a range of functions including health protection, health improvement and screening, which are expected to transfer to Public Health England
- the regional and specialist public health observatories whose staff produce information, data and intelligence on people's health and healthcare for practitioners, policy makers and the wider community
- the cancer registries and the National

Cancer Intelligence Network whose staff are responsible for the collection, analysis, interpretation and dissemination of population-based cancer data
- the National End of Life Care Intelligence Network whose staff aim to improve the collection and analysis of information related to the quality of care provided to adults reaching the end of life to support the improvement of services
- NHS Screening Programmes whose staff lead and support screening programmes in England
- the UK National Screening Committee which is responsible for providing advice on screening to the UK countries
- the quality assurance reference centres whose staff aim to maintain standards in the cancer screening programmes while supporting excellence
- public health staff working in primary care trusts whose functions are expected to transfer to Public Health England including consultants in dental public health who work with a range of partners to improve oral health and ensure patient safety and improved quality in dentistry
- public health staff working in specialised Commissioning Groups who support the effective commissioning of specialised services, and the optimal use of healthcare resources.

Once the final phases of Public Health England's design are completed in the summer of 2012, we will identify the posts that will be needed before Public Health England is established and we will start the process of appointing to them in line with equalities legislation.

This stage will be called the pre-transfer appointment process. We will seek to offer staff as much detail about this process as we can as soon as we can.

We expect a significant majority of staff to be transferred to Public Health England, continuing the roles they currently fulfil.

Confirmation of the full details of the people transfer process will be published in June 2012, as part of the Public Health England People Transition Policy.

The pre-transfer appointment process will then run from July to October 2012 to match existing posts to Public Health England's new establishment.

Our transition milestones for establishing Public Health England are shown in the table on the following page.

[1] The Constitutional Reform and Governance Act 2010 includes provisions relating to the Civil Service. It places the Civil Service values on a statutory footing and includes the publication of a Civil Service Code. More information: www.civilservice.gov.uk/about/values

Transition milestones for establishing Public Health England	
January 2012	Building Public Health England People Transition Policy document published, outlining the high-level process for filling posts, the process for senior appointment and the progress on partnership working Public Health England's running costs and budgets confirmed
June 2012	Full People Transition Policy published with terms and conditions
July to October 2012	Confirmation of employment pools for transfers, and redeployments available Pre-transfer appointment process to match existing posts to new Public Health England establishment
October 2012	Consultation with all staff and trade unions on the transfer process
December 2012 to March 2013	Review and agree Public Health England People Transition Policy for phase two of transfers and appointments
1 April 2013	Public Health England assumes full powers[1]

[1] Subject to the Health and Social Care Bill receiving Royal Assent

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Department of Health

Public Health in Local Government

Factsheets

Department of Health

Local government leading for public health

Local government has a long and proud history of promoting and protecting the public's health dating back to Victorian times. It was only in 1974 that the NHS took over most public health functions. The Government is returning responsibility for improving public health to local government for several reasons, namely their:

- population focus
- ability to shape services to meet local needs
- ability to influence wider social determinants of health
- ability to tackle health inequalities.

Population focus

Local authorities are democratically accountable stewards of their local populations' wellbeing. They understand the crucial importance of "place" in promoting wellbeing. In other words, the environment within which people live, work and play, the housing they live in, the green spaces around them, and their opportunities for work and leisure, are all crucial to their health and wellbeing.

Taking a population perspective, which is at the heart of public health, is a natural part of the role of local government.

Shapers of place

Since local government holds many of the levers for promoting wellbeing it makes sense to give it greater responsibility and power to shape the locality in a healthy direction.

Every day of the year local councils have direct contact with many of their residents. A fully integrated public health function in local government at both strategic and delivery levels offers exciting opportunities to make every contact count for health and wellbeing. This local political leadership is critical to creating the powerful coalitions we need to promote health and wellbeing.

Local authorities are also well placed to release innovation, trying new ways to tackle intractable public health problems. They have considerable expertise in building and sustaining strong relationships with local citizens and service users through community and public involvement arrangements, which will help extend the engagement of local people in the broader health improvement agenda.

Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live work and age, including

the health system. The strength of the evidence linking social determinants to good and poor health has been clearly demonstrated in the Marmot Review (2010) (*Fair Society, Healthy Lives*). Social determinants are one of the main mechanisms driving health inequalities.

Tackling health inequalities

Local authorities have ample experience of the reality of health inequalities in their communities. Many of the social determinants fall within their ambit, so they can take strategic action to prevent inequalities across a number of functions, such as housing, economic and environmental regeneration, strategic planning, education, children and young people's services, fire and road safety.

The Director of Public Health, located within the local authority, will be well placed to bring health inequalities considerations to bear across the whole of the authority's business, and to think strategically about how to drive reductions in health inequalities, working closely with the NHS and other partners.

However, they will also need to look more widely at issues such as crime reduction, violence prevention and reducing reoffending, which may also prevent health inequalities. They can do this through links to existing partnership working and through new relationships, for example with incoming Police and Crime Commissioners.

Looking forward

In one sense the Health and Social Care Bill can be seen to be returning public health home. But at the same time we recognise that local government has changed hugely since 1974, as have the issues for people's health. In particular, there have been major gains from the close integration of public health with clinical services, not least a greater focus on prevention in pathways, on prioritisation and on reaching the whole population.

There is a sound foundation to build on in terms of that close engagement within the NHS, which will remain critical to the delivery of public health goals, in particular in reducing risks, and in primary and secondary prevention.

Local government for its part has moved from a focus on delivering services to a much wider role of shaping local places. Having taken on the key role in promoting economic, social and environmental wellbeing at the local level, it is ideally placed to adopt a wider wellbeing role.

Therefore local leadership for public health is nothing new, but the context has changed. Bringing public health back into local government is not about recreating a pre-1974 landscape. It is about building a new, enhanced locally-led 21st century public health service, where innovation is fostered and promoted, supported by the expertise to be provided by Public Health England. Clear local political leadership will be critical to success.

Our vision for local government leadership of public health

Building on local government's long and proud history of public health leadership, our vision is for local authorities to use their new responsibilities and resources to put health and wellbeing at the heart of everything they do, thereby helping people to lead healthier lives, both mentally and physically.

This means:
- including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- investing the new ring-fenced grant in high-quality public health services;
- encouraging health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people), and the Big Society. This will bring a focus on what a healthy population can do for the local community, not least in terms of regeneration
- tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs, rather than commissioning a plethora of single issue services, and using new technologies to develop services that are easier and more convenient for users
- making effective and sustainable use of all resources, using evidence to help ensure these are appropriately directed to areas and groups of greatest need and represent the best possible value for money for local citizens.

To do this successfully will require a willingness to use all the tools at local authorities' disposal in a new way and not just rely on commissioning traditional services. Public Health England will have a key role in sharing and signposting evidence on the most effective, including cost-effective interventions to improve and protect public health.

For local authorities this will mean working with a wide range of partners across civil society, not least the third sector, including through the shared leadership of health and wellbeing boards. They will be supported in this by HealthWatch, which will better enable people to help shape and improve health and social care services at both a national and, through its seat on the local health and wellbeing board, the local level.

Local authorities already do this up and down the country. From 2013, with new powers and new resources they will be ideally placed to go further in creating healthier communities.

DH Department of Health

Produced: December 2011
Gateway reference: 16747

Produced by the Department of Health
www.dh.gov.uk/publications

Department of Health

Local government's new public health functions

Subject to Parliament, each upper tier and unitary local authority in England will take on a new duty to take such steps as it considers appropriate for improving the health of the people in its area.

An obvious way in which local authorities will fulfil this duty will be commissioning a range of services from a range of providers from different sectors, working with clinical commissioning groups and representatives of the NHS Commissioning Board to create as integrated a set of services as possible.

However, local authorities can fulfil this duty in a wide range of ways, including the way they operate the planning system, policies on leisure, key partnerships with other agencies for example on children's and young people's services, and through developing a diverse provider market for public health improvement activities.

In all they do, local authorities will want to ensure the health needs of disadvantaged areas and vulnerable groups are addressed, as well as giving consideration to equality issues. The goal should be to improve the health of all people, but to improve the health of the poorest, fastest.

Local political leadership will be critical in ensuring that public health receives the focus it needs. The role of the Cabinet lead for health within the council is critical, but there needs to be a much broader engagement in this agenda among all local political leaders.

It will be vital that district councils are closely involved in the development and implementation of local strategies, and that existing health and wellbeing partnerships in two-tier areas are built on in the creation of the new system.

Commissioning

In *Healthy Lives, Healthy People: Update and way forward* we published a provisional list of what should be funded from the public health budget, and who the principal commissioner for each activity should be.

We have sought wherever possible to devolve responsibility and resources for commissioning public health services to local government, although in a number of cases, where a public health service is deeply intertwined with the delivery of clinical services, or where services are part of the primary care contractual arrangements, the Secretary of State for Health will ask the NHS Commissioning Board to commission services on his or her behalf (for example national screening and immunisation programmes).

Our aim is to create a set of responsibilities

which clearly demonstrate local authorities' leadership role in:

- tackling the causes of ill-health, and reducing health inequalities
- promoting and protecting health
- promoting social justice and safer communities.

The list of new local authority responsibilities is set out in the Public Health in Local Government: Commissioning responsibilities factsheet.

For all commissioning decisions, local authorities will want to ensure services are delivered in ways that meet the needs of disadvantaged and vulnerable groups and which consciously respond to the three aims of the equality duty.

Local authorities will also wish to work with clinical commissioning groups to provide as much integration across clinical pathways as possible, maximising the scope for upstream interventions. The health and wellbeing board will be critical to driving this agenda.

We also expect local authorities will wish to commission, rather than directly provide, the majority of services, given the opportunities this would bring to engage local communities and the third sector more widely in the provision of public health, and to deliver best value and best outcomes.

The recent Open Public Services White Paper outlines how modernising public services, ensuring high quality and accessibility, requires increased choice, wherever possible, and public services that are open to a range of providers. It highlights the role that staff-led enterprises have to play in meeting the Government's commitment to improving choice and quality in the delivery of healthcare services. This right to provide[1] enables staff to consider a wide range of options, including social enterprise, staff-led mutuals, joint ventures and partnerships. Their freedom to innovate and respond to service user need will put them in a strong position to drive up quality and improve health outcomes.

We expect promoting choice of provider to drive up quality, empower individuals and enable innovation. It will also provide a vehicle to improve access, address gaps and inequalities and improve quality of services where users have identified variable quality in the past.

Local authorities already have a wealth of experience in commissioning services from a range of providers so we would encourage them to adopt this diverse provider model which will increase the number of service providers, maximising user choice, provided they meet the necessary quality and safety requirements within a price set by commissioners.

This will allow providers to compete for services within the market – a process which is both quicker and less bureaucratic than traditional procurement by competitive tender, which only enables competition for entry into the market. Local authorities should decide which services to prioritise for choice on a diverse provider model based on local needs and priorities. This should be informed by the joint strategic needs assessment and early and continuing engagement with health and wellbeing boards. More information on this can be found at: http://healthandcare.dh.gov.uk/jsnas-jhws-explained

Local authorities are also in an excellent position to test out new and joint approaches to payment by outcomes, such as reducing drug dependency and to extend such approaches with external investment, such as the proposals being developed on social impact bonds to improve services and outcomes.

We envisage that Public Health England will disseminate the learning from such developments with a view to encouraging further innovation at the local level.

Mandatory steps

The Health and Social Care Bill includes a power for the Secretary of State for Health to prescribe that local authorities take certain steps in the exercise of public health functions, including that certain services should be commissioned or provided.

The purpose of this power is not to identify some services as more important than others. Rather the issue is that in some service areas (particularly health protection) greater uniformity of provision is required. In others the Secretary of State for Health is currently under a legal duty and needs to ensure that that obligation is effectively delivered when a function is delegated to local government (the provision of contraception is an example).

Finally, certain other steps are critical to the effective running of the new public health system at a local level, for example, ensuring that the local authority provides public health advice to NHS commissioners.

The mandatory services and steps that were identified in *Healthy Lives, Healthy People: update and way forward* included:

- appropriate access to sexual health services
- steps to be taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- the National Child Measurement Programme
- NHS Health Check assessment.

We previously signalled that we would be mandating elements of the Healthy Child Programme 5-19. More work is still required to model the impact of making any elements of the programme mandatory to ensure value for money. We do not intend to mandate any elements of the programme for 2013.

The net result of these steps will be that local authorities have key responsibilities across the three domains of public health – health improvement, health protection and healthcare public health.

[1] Public health practitioners can find more information on how to exercise the right to provide at: http://healthandcare.dh.gov.uk/right-to-provide-what-it-means-for-nhs-and-social-care-staff

DH Department of Health

Produced: December 2011
Gateway reference: 16747

Department of Health

The role of the Director of Public Health

In taking forward their leadership role for public health local authorities will rely heavily on the Director of Public Health and the specialist public health resources he or she has at their command. Indeed the Health and Social Care Bill makes clear that the Director of Public Health is responsible for exercising the local authority's new public health functions.

We have highlighted the duty on each unitary and upper tier authority to take such steps as it considers appropriate for improving the health of the people in its area.

The Health and Social Care Bill makes clear that each authority must, acting jointly with the Secretary of State for Health, appoint an individual to have responsibility for its new public health functions, known as the Director of Public Health. That individual could be shared with another local authority, where that makes sense (for example, where the senior management team is shared across more than one authority and the authorities are geographically contiguous). Below we cover key aspects of the function and scope of the role of Director of Public Health.

Appointments

We are working with local government and public health stakeholders to produce guidance, which will cover:

- appointments to existing Director of Public Health vacancies in a way that ensures they are fit for purpose for the future
- managing the transition of Director of Public Health posts to local government during 2012/13
- a process for local authorities and Public Health England (in the Secretary of State's behalf), acting jointly, to appoint new Directors of Public Health from 1 April 2013.

The guidance will build on the existing joint appointments process for Directors of Public Health and be consistent with Faculty of Public Health standards, including the use of appointments advisory committees and faculty assessors, and best practice in local government recruitment.

This will ensure Directors of Public Health in local government have the necessary technical, professional and strategic leadership skills to promote, improve and protect health and provide high-level, credible, peer-to-peer advice to the NHS about public health in relation to health services.

Reporting arrangements

We promised in *Healthy Lives, Healthy People: update and way forward* to discuss with stakeholders how best to ensure that that the Director of Public Health has an appropriate status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services.

We have consulted local government and public health interests, and intend to bring forward amendments to the Health and Social Care Bill to reflect our desired policy position. Subject to Parliament, we will add Directors of Public Health to the list of statutory chief officers in the Local Government and Housing Act 1989.

After Royal Assent, we intend to issue statutory guidance on the responsibilities of the Directors of Public Health, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Services.

While the organisation and structures of individual local authorities is a matter for local leadership, we are clear that these legal responsibilities should translate into the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business.

This means that we would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.

Responsibilities

The Director of Public Health as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will in addition make it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. Directors of Public Health will also be statutory members of health and wellbeing boards, and will wish to use the boards as the key formal mechanism for promoting integrated, effective delivery of services.

What these legal responsibilities should translate into is the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business. Thus the Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services. Often the Director of Public Health will not be personally responsible for the problem, but he/she will know how to resolve it through engaging with the right people in the new system. He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director

of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing. In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality.

With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the local authority, but we would expect day-to-day responsibility for the grant to be delegated to the Director of Public Health.

Core skills

To deliver its new public health functions the local authority will need a specialist trained Director of Public Health and public health support with the full range of appropriate skills to deliver the functions we have described. That means we will need to ensure that job descriptions reflect the highest possible standards as set out by the Faculty of Public Health.

It is important to reaffirm that the Government believes the multidisciplinary nature of public health is a key strength of the profession. We believe that the transfer of new public health responsibilities to local authorities in no way changes this, and indeed reaffirms the importance of attracting to public health high-quality individuals from a wide range of disciplines including, but not limited to, medicine.

We will publish a Public Health Workforce Strategy, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a professional public health workforce, set out proposals for how learning and development will be taken forward in the reformed health system, and outline options for how public health knowledge can best be embedded across the wider workforce.

The new arrangements will provide opportunities and challenges for employers, including the wider local authority workforce.

Professional appraisal and support, and capacity building

Continuing professional development is a professional obligation for all public health professionals, both medical and non-medical. It ensures that public health professionals develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving the health of communities. Local authorities will wish to support this professional development.

Way forward

The Director of Public Health's new role offers a great opportunity to build healthier communities. But to make the

most of this Directors of Public Health will need to:

- be fully engaged in the redesign of services that address the coming challenges
- influence and support colleagues who have a key role in creating better health, such as planning officers and housing officers
- facilitate innovation and new approaches to promoting and protecting health, while bringing a rigorous approach to evaluating what works, using the resources of Public Health England
- contribute to the work of NHS commissioners, thus ensuring a whole public sector approach.

Produced: December 2011
Gateway reference: 16747

Department of Health

Commissioning responsibilities

Local authorities will be responsible for:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

We have undertaken a further check of where commissioning responsibilities for a range of services might sit in the future. As part of this work we have taken the opportunity to look again at where commissioning of abortion services might most appropriately be placed.

Given the highly clinical, and in most cases surgical, nature of abortion provision we have reconsidered our earlier decision to place these services with local authorities. We have provisionally concluded that abortion should remain within the NHS and be commissioned by clinical commissioning groups. However, we are keen to seek a range of views on this revised commissioning route. A consultation on this revised recommendation will begin in due course.

In *Healthy Lives, Healthy People: Update and way forward*, we said we were still considering where to place responsibility for sexual assault referral centres (SARCs) and for campaigns to promote early diagnosis of, for example, cancer. We have

decided that, subject to resolving some further points of detail, responsibility for sexual assault services, including SARCs, at least in the short to medium term, should rest with the NHS Commissioning Board. This is in our view the best way to ensure the delivery of uniformly high-quality services across the country. On early diagnosis we are committed to giving both Public Health England and the NHS Commissioning Board clear responsibility for delivery, based on a shared set of outcomes.

Only some of the above services are to be mandated. The commissioning of other services will be discretionary, guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy.

There was considerable comment during our consultation on commissioning responsibilities about the split of responsibilities for the public health of children and young people, including the Healthy Child Programme, with pregnancy to five services being commissioned by the NHS Commissioning Board. We accept the many benefits to be had from the integration of public health into the wider commissioning of children's and young people's public health, particularly in terms of the prevention and safeguarding agendas.

As we explained in *Healthy Lives, Healthy People: Update and way forward*, we believe that the NHS Commissioning Board will be best placed to lead the commissioning of public health funded services for children under five in the first instance, including health visiting, the Healthy Child Programme and Family Nurse Partnership, given the commitment to a 50% increase in the health visiting workforce and a transformation in the health visiting service by 2015, and to ensure associated improvements in support for families.

Our medium-term aim is to unify responsibility for these services within local government by 2015 when the increased health visiting workforce and new health visiting service model and the Healthy Child Programme offer to families should be in place. In line with this direction of travel, we are also transferring responsibility for commissioning effective Child Health Information Systems to the NHS Commissioning Board, also to be funded by the public health budget. This decision will be reviewed in 2015 to determine longer-term plans. We will engage further on the detail of these proposals, particularly in respect of transition arrangements and the best way to begin to involve local authorities in local commissioning of these services in partnership with the NHS.

In the meantime, Public Health England will retain a close interest in the specification of Child Health Information Systems, to ensure public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.

The list of commissioning responsibilities above is of course not exclusive. Local authorities may choose to commission a wide variety of services under their health improvement duty, and indeed we would hope to see much innovation as local authorities embrace their new duties. This freedom is deliberately wide, to encourage

the kind of locally-driven solutions that lie at the core of localism, underpinned by a robust analysis of the needs and assets of the local population. Public Health England will promote this local innovation through encouraging peer sharing of best practice and learning experiences, and through supporting rigorous evaluation of new approaches to improving and protecting public health.

Sexual health services

Local authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) testing and treatment services, for the benefit of all persons of all ages present in the area. Transfer of these services offers great opportunities to integrate sexual health services and to link services to wider services, including alcohol and drugs, for particular target groups, such as young people, vulnerable people and other groups at risk of sexual ill-health.

We are going beyond merely transferring responsibility for sexual health services to local authorities and actually mandating them for two reasons. First, STI testing and treatment services are a central part of protecting health. The Government therefore believes that high-quality services must be available in all areas, although the services provided will be tailored to meet local needs.

Second, the Secretary of State for Health currently has a duty, reiterated in the Health and Social Care Bill, to provide advice on contraception, medical examination of people seeking advice on contraception, the treatment of these people, and the supply of any contraceptive substances and appliances. This duty is currently delegated to primary care trusts, who are required to provide open-access services which are not limited to their own residents. Mandating these services of local authorities in the future will allow the Secretary of State for Health to meet this duty fully, over and above what is provided for via current GP provision.

Health protection plans

At present Directors of Public Health in primary care trusts play a key leadership role in planning for, and responding to, health protection incidents, supported by local Health Protection Agency health protection units. Subject to Parliamentary approval, the Health and Social Care Bill will provide that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population. However, we want the Director of Public Health to continue to provide a coordination role to protect the health of the local population when transferred to local authorities. Our vision is that the local authority, and the Director of Public Health acting on its behalf, should have a pivotal place in protecting the health of its population. We therefore propose to use a regulation-making power in the Bill to require local authorities to take steps to ensure that plans are in place to protect the local population.

Under this duty, local authorities (and Directors of Public Health on their behalf) would be required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-

scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated.

Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population, working with Public Health England which will provide specialist health protection services including, for instance, coordination of outbreak control, and access to national expert infrastructure as and when necessary. His or her role in delivering these functions will be supported by the transparency in the system that will allow the Director of Public Health and others rapid access to routine monitoring data.

Below we set out in brief how we envisage this health protection role working.

With regard to emergencies, we plan the following. At the Local Resilience Forum (LRF) level, a lead Director of Public Health from a local authority within the LRF area will be agreed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.

Public Health England will continue to provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.

The NHS Commissioning Board will appoint a lead director for NHS emergency preparedness and response at the LRF level, and provide necessary support to enable planning and response to emergencies that require NHS resources.

Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. LHRPs will consist of emergency planning leads from health organisations in the LRF area and will ensure effective planning, testing and response for emergencies.

LHRPs are a formalisation of existing health subgroups found in the majority of LRF areas. They will enable all health partners to input to the LRF and in turn provide the LRF with a clear, robust view of the health economy and the best way to support LRFs to plan for and respond to health threats. Further work will be done over the coming months to pilot and plan the resourcing and operation of LHRPs.

The lead director appointed by the NHS Commissioning Board and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning. Resources will be required to support the LHRP to provide continuous readiness.

More work will take place in the coming months to develop operational guidance for the system-wide emergency preparedness, resilience and response model.

The NHS lead director will represent the LHRP on the LRF, as now, since most

emergencies require readiness and input of NHS resources. The lead Director of Public Health should also attend, and Public Health England will attend where the emergency requires its presence.

In terms of plans for screening and immunising the local population we envisage a process as follows. The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes in accordance with an agreement between the Secretary of State for Health and the Board which will set out the terms in which the Board will exercise a Secretary of State function. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening.

Directors of Public Health will advise, for example, on whether screening or immunisation programmes in their area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS Commissioning Board on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board on issues such as raising uptake of immunisations and screening, and how outcomes might be improved by addressing local factors. They will also have a role in championing screening and immunisation, using their relationships with local clinicians and clinical commissioning groups, and in contributing to the management of serious incidents.

Directors of Public Health will play a role in ensuring that immunisation care pathways for programmes such as neonatal hepatitis B are robust. The Board will remain accountable for responding appropriately to that challenge from local public health teams, and for driving improvement.

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority Director of Public Health and his or her team to identify any issues and advise appropriately. But it will be underpinned by legal duties of cooperation, contractual arrangements, clear escalation routes and transparency.
Thus clinical commissioning groups will have a duty of cooperation with local authorities; NHS-funded providers can be required through contracts to share plans and appropriate information; Directors of Public Health can use their annual report and membership of the health and wellbeing board to raise concerns more formally; and the Secretary of State for Health can use the Mandate and his agreement with the Board to ensure that the NHS Commissioning Board takes appropriate account of the advice of Directors of Public Health.

Finally, there will be a professional relationship between Directors of Public Health and Public Health England, and the Chief Medical Officer as professional lead for public health, which will give directors and their teams a route for contributing to national thinking about what is needed.

The system ensures that accountability is focused where it needs to be. The Director of Public Health will be

responsible as the public health lead in each local authority for advising on plans that are in place and identifying any problems, using his or her public health expertise. NHS and other partner colleagues will be accountable for taking appropriate account of that advice.

This is in line with the design of the new system overall: Public Health England and Directors of Public Health are accountable for the provision of high-quality public health advice; the NHS Commissioning Board, clinical commissioning groups and others are accountable for making the appropriate use of that advice.

The Secretary of State for Health will retain a central interest in health protection even where he has delegated functions to the local level. To this end we will publish further details as we develop policy on the new system. In particular we will develop a statement on how we will promote high performance and support performance improvement.

We also intend to produce operational guidance to support incident management at a local level, which will cover the working relationship between the NHS, Public Health England and the local authority. The guidance will recognise the need for flexibility to enable each area to make plans most appropriate to protect the health of its population.

Population healthcare advice to the NHS

We will also mandate local authorities to provide population healthcare advice to the NHS. Good population health outcomes, including reducing health inequalities, rely not just on health protection and health improvement, but on the quality of healthcare services provided by the NHS. That is why we are preserving a key role for local authority public health teams in providing public health expertise for the NHS commissioners of these services.

The need to secure provision of public health expertise for healthcare commissioners (and to support health and wellbeing boards in producing the joint strategic needs assessment and joint health and wellbeing strategy) was a key theme of the consultation on the public health white paper *Healthy Lives, Healthy People*.

We have consulted a group of public health and other experts who have developed a draft model for what such a public health advice service might look like, building on existing work across the country. Appendix 1 sets out the group's recommendations, aligned against the stages of the commissioning cycle.

Clinical commissioning groups will require a range of information and intelligence support via both the population healthcare advice service based in local authorities and other commissioning support services such as from Public Health England where appropriate. It is important to note that although there are some similarities in the nature of these services (ie public health population healthcare advice and the work of commissioning support organisations (CSOs) in the future), they will have a different focus.

We envisage that public health teams will provide largely a strategic population focus, synthesizing data from a wide variety of sources and applying their public health skills to draw the implications of that data for the local population. CSOs will focus more on commissioning processes and clinical systems, including detailed analysis of referrals and activity, procurement and business processes. Both are essential for driving improvements in services.

There would be nothing to stop local authorities from agreeing locally to offer a wider range of services. Local authorities will also be free to meet this obligation in a variety of ways, for example in relatively small authorities it may make sense to locate a team in a single authority, acting on behalf of several. In addition, Public Health England will have a role through its information and intelligence service to support local authorities on this mandatory duty. This could include, for example, providing baseline data and analysis that local public health teams would need to share with the local NHS to inform discussions about relative needs and priorities.

Given close working and responsiveness between public health teams and clinical commissioners we would expect clinical commissioners to make full use of the expertise of local public health teams (as well as public health expertise in clinical senates). Indeed we are confident that as fully integrated commissioning teams are put in place throughout the country, the nature and extent of such assistance will be an accepted and automatic core element of local commissioning practice. This will be another means of taking forward the underpinning localism ambitions of this policy approach.

Where there are concerns about the quality of the advice received we would expect this to be raised at the local level initially with the local authority. There may be an issue of professional development, in which case we would envisage clinical commissioning groups involving Public Health England in discussions.

We are considering further what role local public health advice may play in supporting the NHS Commissioning Board in its core responsibilities, for example with respect to the quality of local primary care commissioning.

The group of public health experts and GPs who have advised us on the development of the population healthcare advice service are also working with us to consider how best to ensure that the provision of population healthcare advice meets the needs of clinical commissioning groups. This will help ensure that clinical commissioning groups can be confident that they will receive the kind of high-quality, responsive service they need.

DH Department of Health

Produced: December 2011
Gateway reference: 16747

Produced by the Department of Health
www.dh.gov.uk/publications

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Public health advice to NHS commissioners

Strategic planning: assessing needs

Public health advice to NHS commissioners	Examples
Supporting clinical commissioning groups to make inputs to the joint strategic needs assessment and to use it in their commissioning plans	Joint strategic needs assessment and joint health and wellbeing strategy with clear links to clinical commissioning group commissioning plans
Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with the clinical commissioning groups and local authorities	Neighbourhood/locality/ practice health profiles, with commissioning recommendations
Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality	Clinical commissioners supported to use health related datasets to inform commissioning
Health needs assessments for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures	Health needs assessments for condition/disease group with intervention/commissioning recommendations

Strategic planning: reviewing service provision

Public health advice to NHS commissioners	Examples
Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the equality duty	Vulnerable and target populations clearly identified; public health recommendations on commissioning to meet health needs and address inequalities
Support to clinical commissioning groups on interpreting and understanding data on clinical variation in both primary and secondary care. Includes public health support to discussions with primary and secondary care clinicians if requested	Public health recommendations on reducing inappropriate variation
Public health support and advice to clinical commissioning groups on appropriate service review methodology	Public health advice as appropriate

Strategic planning: deciding priorities

Public health advice to NHS commissioners	Examples
Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence base for the setting of priorities	Review of programme budget data Review of local spend/ outcome profile
Advising clinical commissioning groups on prioritisation processes – governance and best practice	Agreed clinical commissioning group prioritisation process
Work with clinical commissioners to identify areas for disinvestment and enable the relative value of competing demands to be assessed	Clear outputs from clinical commissioning group prioritisation
Critically appraising the evidence to support development of clinical prioritisation policies for populations and individuals	Clinical prioritisation policies based on appraised evidence
Horizon scanning: identifying likely impact of new National Institute for Health and Clinical Excellence guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	Public health advice to clinical commissioners on likely impacts of new technologies and innovations

Procuring services: designing shape and structure of supply

Public health advice to NHS commissioners	Examples
Providing public health specialist advice on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning)	Public health advice on focusing commissioning on effective/cost-effective services
Providing public health specialist advice on appropriate service review methodology	
Providing public health specialist advice to the medicines management function of the clinical commissioning group	Public health advice to medicines management, for example ensuring appropriate prescribing policies

Procuring services: planning capacity and managing demand

Public health advice to NHS commissioners	Examples
Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes	Public health advice on development of care pathways/specifications/ quality indicators
Public health advice on modelling the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	Public health advice on relevant aspects of modelling/ capacity planning

Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views

Public health advice to NHS commissioners	Examples
Public health advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance	Clear monitoring and evaluation framework for new intervention/service public health recommendations to improve quality, outcomes and best use of resources
Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes	
Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out health equity audits and to advise on health impact assessments	Health equity audits Public health advice on health impact assessments and meeting the public sector equality duty
Interpreting service data outputs, including clinical outputs	Public health advice on use of service data outputs

The National Child Measurement Programme

The National Child Measurement Programme (NCMP) annually weighs and measures children in reception year and year six in maintained schools in England. The NCMP provides high-quality, locally reliable data on child overweight and obesity levels and trends. This surveillance data is key to improving our understanding of overweight and obesity in children and is used both locally and nationally to inform the planning and development of policy and programmes. It also provides an opportunity to raise public awareness of child obesity and to assist families to make healthy lifestyle changes through provision of a child's result to their parents.

The quality and reliability of the data gathered through the NCMP is dependent on sustaining a high participation rate within every area, and on the data being collected in a consistent way. This ensures: a complete picture of the national prevalence of child obesity; consistency of data between areas; local data that is as robust as possible; and year-on-year, allows reliable statistical comparisons to be made.

To ensure that the quality of the data is maintained, in addition to giving local authorities funding and power to deliver the NCMP as part of their local public health responsibilities, the Government will mandate the collection and return of NCMP data so that the programme can continue to successfully fulfil its public health surveillance function.

NHS Health Check Assessment

The NHS Health Check programme is for people in England aged 40 to 74 and aims to prevent heart disease, stroke, diabetes and kidney disease, which account for a significant burden of ill health and premature mortality. It is a risk assessment and risk management programme, and both elements are important. Those receiving a NHS Health Check risk assessment need to be supported to manage their risk through appropriate follow-up. The Government intends to mandate local authorities to offer everyone eligible between the ages of 40-74 a Health Check assessment every five years. While the provision of lifestyle advice and interventions will not be mandated, there is an expectation that local authorities will commission appropriate services and ensure that the NHS Health Check assessments are adequately followed up.

Local authorities will need to work closely with clinical commissioning colleagues to ensure that people identified as high risk through their assessment, or requiring additional testing or medical interventions are provided with the services they need. This is an area which the health and wellbeing board may wish to focus on to ensure that there is a well-integrated system, where checks are properly followed up by appropriate treatment.

Produced: December 2011
Gateway reference: 16747

Produced by the Department of Health
www.dh.gov.uk/publications

Department of Health

Professional appraisal and support, and capacity building

Continuing professional development is a professional obligation for all public health professionals, both medical and non-medical, but there are currently different legal requirements for professional appraisal of public health specialists who are doctors and those from a non-medical background.

Since November 2009, a doctor must have held a licence to practise medicine. It is planned that this licence should be renewed every five years in a process known as revalidation.

The Medical Profession (Responsible Officers) Regulations 2010 give senior doctors in designated bodies functions for specified doctors that will ensure doctors are regularly appraised and where there are concerns about a doctor's fitness to practise, they are investigated and, where appropriate, referred to the General Medical Council.

The regulations also give the Secretary of State for Health the powers to nominate a responsible officer for a designated body where the body has failed to nominate or appoint a responsible officer in accordance with regulations or where the body appoints a person that does not meet the conditions set out in regulations.

We recognise that for specialists working in Public Health England and in local authorities, revalidation will be an important focus for maintaining and improving their practice. Responsible officers will play a crucial role in the process of medical revalidation.

Non-medical specialists are not currently subject to the same legal requirements in relation to revalidation. However, the Department of Health will also expect non-medical public health specialists to undergo a professional appraisal.

We are considering a number of options including guidance to encourage this process to take place.

The Faculty of Public Health is the standard-setting body for specialists in public health and has an important role in continuing professional development. The Faculty also provides guidance on both appraisal and revalidation.

The Faculty has also published Good Public Health Practice that sets out the general professional expectations of public health professionals.

We know that specialists in public health will be committed to following this guidance. Public health leaders in Public Health England will support this,

for example, by offering to conduct professional appraisal for directors of public health and for public health specialists in local authorities.

The professional appraisal will link with the managerial appraisal undertaken by local authority chief executives.

Public Health England will support public health professionals to follow frameworks of good practice and will work with local government to improve and innovate in public health practice.

DH Department of Health

Produced: December 2011
Gateway reference: 16747

Produced by the Department of Health
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